STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING _____ B. WING _____	C 02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	**7935 CALUMET AVE MUNSTER, IN 46321**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00164136 and IN00166425. Complaint IN00164136- Substantiated. No deficiencies related to the allegation are cited. Complaint IN00166425- Substantiated. No deficiencies related to the allegation are cited. Survey dates: February 26 & 27, 2015 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Survey Team: Janet Adams, RN-TC Census bed type: SNF: 24 SNF/NF: 182 Total: 206 Census Payor type: Medicare: 47 Medicaid: 108 Other: 51 Total: 206 Sample: 5 Munster Med Inn was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00164136 and IN00166425.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE